DOCUMENT RESUME

ED 339 987 CG 023 900

TITLE Psychosocial Aspects of HIV and AIDS and the Evaluation of Preventive Strategies: Report on a WHO Meeting (Lisbon, Portugal, May 28-June 1, 1990). WHO Regional Publications, European Series, No. 36.

INSTITUTION World Health Organization, Copenhagen (Denmark). Regional Office for Europe.

REPORT NO ISBN-92-890-1127-0; ISSN-0378-2255
PUB DATE 90
NOTE 55p.
AVAILABLE FROM Regional Programme on AIDS, WHO Regional Office for Europe, Scherfigsvej 8, DK-2100 Copenhagen 0, Denmark (10.00 sw.fr.).
PUB TYPE Collected Works - Conference Proceedings (021)

EDRS PRICE MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS *Acquired Immune Deficiency Syndrome; Behavior Change; Behavior Patterns; Elementary Secondary Education; Higher Education; *Prevention; Program Development; Psychological Patterns; Social Behavior

ABSTRACT

The spread of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) depends very much on the way people behave. Individuals from some groups have been successfully persuaded to modify behaviors that put them at increased risk of HIV infection. The salient questions for future AIDS prevention and control programs are about how this modification actually came about, and how the progress achieved can be consolidated. Psychosocial factors have a vital role in influencing the behavior of both individuals and groups. At the fourth in a series of World Health Organization meetings on AIDS issues, 76 participants met to discuss the psychosocial aspects of HIV infection and AIDS, and to look at the importance of behavioral factors in planning and evaluating strategies for prevention and control. They felt that studies of knowledge, attitudes, and behaviors and practices can be a valuable tool for national AIDS programs if carried out and used appropriately. They emphasized the importance of maintaining the quality of program monitoring and evaluation. They identified school and college students as vital target audiences for AIDS education, and providers of health, education, and social services for training in AIDS issues. Finally, they encouraged policy-makers and program managers to establish partnerships with journalists, as the most efficient means of reaching the largest number of people. (LLL)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED339987

CG023900

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☒ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL IN MICROFICHE ONLY HAS BEEN GRANTED BY

F. E. Theakston

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

BEST COPY AVAILABLE

The World Health Organization is a specialized agency of the United Nations with primary responsibility for international health matters and public health. Through this Organization, which was created in 1948, the health professions of some 165 countries exchange their knowledge and experience with the aim of making possible the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.

The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health problems of the countries it serves. The European Region has 31 active Member States,[a] and is unique in that a large proportion of them are industrialized countries with highly advanced medical services. The European programme therefore differs from those of other regions in concentrating on the problems associated with industrial society. In its strategy for attaining the goal of "health for all by the year 2000" the Regional Office is arranging its activities in three main areas: promotion of lifestyles conducive to health; reduction of preventable conditions; and provision of care that is adequate, accessible and acceptable to all.

The Region is also characterized by the large number of languages spoken by its peoples and the resulting difficulties in disseminating information to all who may need it. The Regional Office publishes in four languages — English, French, German and Russian — and applications for rights of translation into other languages are most welcome.

---

[a] Albania, Austria, Belgium, Bulgaria, Czechoslovakia, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Luxembourg, Malta, Monaco, Netherlands, Norway, Poland, Portugal, Romania, San Marino, Spain, Sweden, Switzerland, Turkey, USSR, United Kingdom and Yugoslavia.

Psychosocial aspects of HIV and AIDS and the evaluation of preventive strategies

WHO Library Cataloguing in Publication Data

Psychosocial aspects of HIV and AIDS and the evaluation of preventive strategies : report on a WHO meeting, Lisbon, 28 May–1 June 1990

(WHO regional publications. European series ; no. 36)

1.Acquired immunodeficiency syndrome – prevention & control
2.Acquired immunodeficiency syndrome – psychology
3.HIV infections – prevention & control 4.HIV infections – psychology
5.Health education 6.Evaluation studies I.Series

ISBN 92 890 1127 0 (NLM Classification: WD 308)
ISSN 0378–2255

World Health Organization
Regional Office for Europe
Copenhagen

WHO Regional Publications, European Series, No. 36

Psychosocial aspects of HIV and AIDS and the evaluation of preventive strategies

Report on a WHO meeting

Lisbon
28 May –1 June 1990

ICP/OPA 058
Text editing by: M. S. Burgher

ISBN 92 890 1127 0
ISSN 0378 2255

©World Health Organization 1990

Publications of the World Health Organization enjoy copyright protection in accordance with the provisions of Protocol 2 of the Universal Copyright Convention. For rights of reproduction or translation, in part or *in toto*, of publications issued by the WHO Regional Office for Europe applications should be made to the Regional Office for Europe, Scherfigsvej 8, DK-2100 Copenhagen Ø, Denmark. The Regional Office welcomes such applications.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the Secretariat of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. The names of countries or areas used in this publication are those that obtained at the time the original language edition of the book was prepared.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

The views expressed in this publication are those of the contributors and do not necessarily represent the decisions or the stated policy of the World Health Organization.

PRINTED IN DENMARK

CONTENTS

Page

Introduction 1

Scope and purpose 2

Background 4

Role of WHO in prevention and control 4

Epidemiological update 6

Update on national policies and programmes 7

Discrimination 8

A health promotion framework for AIDS prevention 9

Prevention strategies in Portugal 11

Social and behaviourial research 12

Experience with and usefulness of studies 12

Obstacles and ways to overcome them 14

Monitoring and evaluation 18

Evaluation issues 19

Guidance on monitoring and evaluation 20

Target audiences 22

Selection criteria 22

Newly recognized audiences and needs 24

Appropriate and effective messages 25

Sustaining public interest and mobilizing society 27

Four essential allies 28

Methods 29

Conclusions 30
Social and behavioural research 30
Monitoring and evaluation 30
Target audiences 31
Sustaining public interest 31
AIDS policies and programmes 32
Support for national programmes 32

Recommendations 34
Social and behavioural research 34
Monitoring and evaluation 34
Target audiences 35
Sustaining public interest 35
AIDS policies and programmes 35
Support for national programmes 35

Annex 1. Working papers 37

Annex 2. Participants 39

Introduction

The WHO European Regional Meeting on Psychosocial Aspects of HIV/AIDS and the Evaluation of Preventive Strategies was held in Lisbon from 28 May to 1 June 1990, and organized by the WHO Regional Office for Europe jointly with the Ministry of Health and the National AIDS Committee of Portugal. It was the fourth in a series of European regional meetings to consider and stimulate a broadly based, intersectoral public health approach to the prevention and control of the human immunodeficiency virus (HIV) and the acquired immunodeficiency syndrome (AIDS).

The 76 participants included representatives from 30 European Member States, the Commission of the European Communities, the WHO Regional Office for Europe and WHO headquarters. The working papers are listed in Annex 1 and the participants in Annex 2.

The participants were welcomed by Professor A. Coelho, Director of the National Institute of Health in Lisbon; Dr Ilona Kickbusch, Director, Lifestyles and Health at the Regional Office for Europe; and Dr M. Carballo of the Global Programme on AIDS. The Meeting was opened by Dr A. de Carvalho, Minister of Health of Portugal. The Chairperson of the meeting was Professor Laura Ayres. Ms Jo Kittelsen served as Vice-Chairperson, Dr A. Gromyko as Secretary and Dr M. Kapila as Rapporteur.

Scope and purpose

The AIDS epidemic has many complex biomedical, epidemiological, social, ethical and legal dimensions. There is an increasing recognition of the vital and fundamental role of psychosocial factors in influencing the behaviour of individuals and groups, determining who is vulnerable to HIV infection, creating opportunities for prevention and determining the obstacles to risk reduction, and shaping the responses of communities, professionals and policy-makers. The way in which these issues should be taken into account in the design of strategies to prevent and control HIV and AIDS, however, is not always clear. Similarly, while the need for monitoring and evaluation is generally acknowledged, much more needs to be done to use such work in designing effective programmes.

The Lisbon Meeting was therefore held to discuss the psychosocial aspects of HIV infection and AIDS and the importance of behavioural factors in planning and evaluating strategies for prevention and control. In plenary sessions and working groups, the participants were asked:

— to share experience gathered in countries, including the lessons to be learnt from programme innovations and models of good practice;

— to identify problems and deficiencies in the development and implementation of policies and programmes, and the extent to which these have been successfully managed;

— to clarify future directions and priorities;

— to suggest action to be taken by national AIDS committees and programmes, nongovernmental and other organizations in the public and private sectors,

— to examine the link between AIDS and other national health priorities and programmes, to foster mutual learning and to strengthen prevention and control efforts; and

— to advise WHO on how to support national programmes for the prevention and control of HIV infection and AIDS.

To provide a practical focus for the discussions, four broad programmatic areas were considered:

— the contribution of research (particularly studies of knowledge, attitudes, behaviours and practices);

— the quality and extent of programme monitoring and evaluation;

— the targeting of prevention and control initiatives; and

— planning to sustain public interest and ensure effective multisectoral involvement.

Background

Role of WHO in Prevention and Control

The 31 Member States of the WHO European Region have committed themselves to the prevention and control of HIV infection and AIDS, as part of the global strategy against the disease. To stimulate and support national efforts in this direction, the WHO Regional Office for Europe has developed an active programme that started with a meeting in 1983. The first response was to establish a regional epidemiological surveillance system for AIDS, which is now supported by all the Member States of the Region.

A regional meeting in 1985 helped to develop the first guidelines on AIDS prevention. At three subsequent major regional meetings, in 1986–1989, WHO provided a forum in which coordinators of national AIDS programmes could discuss the epidemic and strategies for its prevention and control. In addition, numerous technical meetings, consultations and workshops have been held on topics such as:

— prevention strategies in European countries with low prevalences of HIV infection and AIDS;

— counselling;

— the involvement of AIDS service organizations and other nongovernmental organizations;

— legislative and ethical aspects; and

— the monitoring and evaluation of AIDS education and health promotion programmes.

Further a network of WHO collaborating centres in the Region has developed key activities in basic research, surveillance and epidemiological investigation, care and counselling, and health promotion.

In messages to the Meeting in Lisbon, Dr H. Nakajima, WHO Director-General, and Dr J.E. Asvall, WHO Regional Director for Europe, made clear their commitment to maintaining the momentum of European prevention and control efforts. These would receive the necessary priority and support as part of the overall work of WHO.

In addition, five future priorities for the WHO Global Programme on AIDS were outlined by its Director, Dr M.H. Merson. First, collaboration with national AIDS committees is to be strengthened, to improve the effectiveness of prevention and control programmes. Sustainable approaches soundly based on public health are the cornerstone. Second is accelerated research and development. This includes studies of prevention-related interventions. The third priority is to deal with the problems of complacency. A fuller understanding of the epidemic, communicated through a more imaginative presentation of its social and economic effects, is critical to overcoming a denial of the extent of the problem by the public and policy-makers. Fourth, human rights must be protected and discrimination countered. This is crucial to the success of public health initiatives. Finally, the internal management of the Global Programme is to be strengthened. The Programme is being reorganized and decentralized to regional offices and countries, while central leadership is retained in essential tasks such as advocacy and mobilizing resources, developing guidelines, coordinating research and liaising with other United Nations bodies. The outcome of the Lisbon Meeting was expected to help decide the future direction of work for the Global Programme on AIDS in Europe.

Epidemiological Update

As of the end of March 1990, the (then) 32 European Member States had reported a cumulative total of 34 967 AIDS cases to WHO. Of these, 46% were categorized as resulting from homosexual or bisexual contact, 32% from the injection of drugs, 8% from heterosexual contact and 7% from the receipt of blood and blood products. Further, 2% of cases were due to perinatal transmission and in 5% complete information was not available.

Children under 13 years accounted for 819 cases (2% of the total). In cases in adults and adolescents the ratio of males to females was about 7:1.

The reported cases of AIDS, however, are a gross underestimate of the true burden of HIV infection. WHO estimated this to be 500 000 in the European Region, out of an estimated global total of about 6 million in May 1990. Although 80% of the infected people in Europe are male, the proportion of females is increasing and carries significant implications for perinatal transmission, and child morbidity and mortality. By the end of 1991, a cumulative total of 60 000–78 000 AIDS cases is expected in the European countries most affected by the epidemic. The European Region is characterized by multiple epidemics among the people at risk, and differences within the Region can be crudely reflected in four patterns:

(*a*) an epidemic predominantly among homosexual men, with a stable or declining incidence of AIDS (mostly found in northern Europe);

(*b*) a rising prevalence of HIV infection, principally from the injection of drugs (mostly found in countries on the Mediterranean Sea, such as Italy, Spain and Yugoslavia);

(*c*) a mixed pattern, with increasingly well established transmission through heterosexual contact and the injection of drugs (found in, for example, France and Switzerland); and

(*d*) an emerging picture in which the reporting of AIDS is still at an early stage, with significant nosocomial spread of HIV reported in some countries (found in eastern Europe).

The regional epidemiological AIDS surveillance system is being extended to include a European HIV database. This now includes information (standardized as far as possible) from Member States on studies of HIV seroprevalence. In the future, the further development and analysis of the HIV database is expected to provide valuable information for planning.

Update on National Policies and Programmes

The various approaches of the European Member States to the prevention and control of HIV infection and AIDS, and their progress, are described in two documents available from the WHO Regional Office for Europe.[a]

As the European experience of AIDS enters its second decade, new concerns have arisen in the Region. For example, the increase in AIDS incidence is slowing in some countries and projections have been revised downwards. In addition, social and political changes in eastern and central Europe have increased both the risk of HIV spread and the opportunities for prevention. Third, the increasing number of people with HIV and AIDS need care and psychosocial support. Finally, policymakers are demanding more concrete information on the impact, particularly the cost-effectiveness, of programmes.

To assess evolving country responses, an updated review was presented at the Meeting of the policies and programmes of Member States, on the basis of information supplied by them. Four major trends were observed in the Region.

The composition of national AIDS committees has broadened to include greater multicisciplinary and intersectoral representation, and nongovernmental and AIDS service organizations are more actively involved. There is progress in positively influencing intermediaries between AIDS

[a] **Wayling, S.** *AIDS policies and programmes in the European Region.* Copenhagen, WHO Regional Office for Europe, 1989 (unpublished document EUR/ICP/GPA 040) and **Wayling, S.** *1990 update: current status of HIV/AIDS prevention and control policies in the European Region.* Copenhagen, WHO Regional Office for Europe, 1990 (unpublished document EUR/ICP/GPA 079).

programmes and the public, such as the mass media, and in better informing policy- and decision-makers. Further, the financial resources of programmes are more effectively used, guided by improved estimates of need. Finally, recognition is increasing of the importance of cooperation between national, centrally directed and local, decentralized efforts that are:

— aimed at individuals and communities at risk, such as injecting drug users;

— conveniently located in settings such as schools and workplaces;

— concerned particularly with hard-to-reach groups such as migrants and refugees;

— concerned with promoting social tolerance, protecting individual human rights and preventing discrimination;

— intended to encourage behaviour change, as opposed to simply creating awareness; and

— aware of the need for adequate monitoring and evaluation.

These changes indicate that the progress being made is consistent with accepted guidelines on good practice in the prevention and control of HIV infection and AIDS. Important differences between and within countries remain, however, revealing the need for a renewed and clear commitment to the priorities (particularly equity) set out in the WHO strategy for health for all.

In addition, the countries of central and eastern Europe, with limited resources, face particular economic and other difficulties in implementing measures to prevent and control HIV and AIDS. These countries require urgent attention and support.

Discrimination

Arising from the AIDS epidemic is the central concern with defending the rights of individuals while protecting society against the spread of HIV. Public health experience indicates clearly that respecting the dignity and human rights of people

with HIV or AIDS, and other marginalized or vulnerable groups, is vital to the success of national AIDS programmes. The reason for this is clear. If having HIV or AIDS leads to stigmatization and discrimination (such as the loss of employment or the opportunity for education, separation from the family, or the loss of social and family benefits), then people who are infected with HIV or those who are concerned that they may be at risk are likely to avoid detection and contact with the health and social services. Thus, those most in need of education, counselling and other support services will be least likely to seek them.

Resolution WHA 41.24 of the Forty-first World Health Assembly urged Member States to protect the human rights and dignity of people with HIV or AIDS and to avoid discriminatory measures and stigmatization. At a WHO European regional meeting held in the same year, 1988, the participants called for the examination of national legislation to assess its effectiveness and ethical acceptability in relation to the AIDS epidemic, and for the removal of regulations that were irrelevant, outdated or counterproductive. In 1990 the WHO Director-General also requested Member States to review their policies and laws related to HIV and AIDS. It would be helpful to review the progress being made in this regard by the Member States in the European Region.

A Health Promotion Framework for AIDS Prevention

Epidemiological differences between and within countries indicate that the AIDS epidemic, like many other public health problems, disproportionately afflicts the poor and disadvantaged. These inequalities must be addressed if preventive work is to succeed. Further, the experience gained from many programmes clearly suggests that the simple provision of information is inadequate to evoke the behaviour from individuals and society that will be necessary to control the epidemic. Hence a different approach — based on the principles of health promotion — is essential.

The AIDS epidemic started in the 1980s, at about the same time as the emergence of a new public health. This saw the growth of a better understanding of the complex factors that shape health, and the ways in which they may be influenced. The core of this concept of health promotion is concerned with personal empowerment and communal action through: developing personal skills, strengthening community action, creating supportive environments, reorienting health services and building healthy public policies.

All these areas are closely linked, and an integrated and comprehensive approach is a major characteristic of health promotion. Examples of effective AIDS prevention and control measures based on the principles of health promotion are available from Europe and elsewhere. Within this framework, key current issues in prevention include:

(*a*) maintaining government commitment and momentum, including adequate resources, while adjusting programme direction and focusing activities according to considerations of equity;

(*b*) cooperating to achieve a multiplication of results and not simply a duplication of efforts;

(*c*) linking AIDS work with the mainstream of public health development so that each learns from and strengthens the other, and both move towards more comprehensive and integrated health promotion strategies;

(*d*) closing the gap between the people who do research and those who use it, which includes the translation of evaluation data into policy options that can be the basis of rational decision-making; and

(*e*) adopting appropriate indicators to track progress, setting targets for these indicators and devising ways of measuring them.

These practical issues are critical in the further development of national AIDS programmes derived from fact-based, pragmatic policies.

Prevention Strategies in Portugal

A presentation on the Portuguese experience served as an example of a programme to prevent HIV infection and AIDS carried out at the national level.

Portugal (with a population of 10 million) had reported 410 AIDS cases to WHO by the end of March 1990 (46% resulting from homosexual or bisexual contact, 20% from heterosexual contact, 12% from the injection of drugs, 10% from the receipt of infected blood or blood products, and 11% from other or unknown means of transmission). A characteristic feature of AIDS in Portugal is the high proportion (10%) of infection with the second strain of HIV (HIV2). Epidemiological monitoring suggests that the epidemic is progressing most rapidly through the injection of drugs and heterosexual contact.

An AIDS Working Group was created in 1985, and evolved into a multisectoral Consultative Committee in 1990. The major educational activities undertaken include the distribution of information leaflets to all households, exhibitions around World AIDS Day, information campaigns directed at travellers and the general public, briefings for politicians, and training for doctors, nurses and other health care workers. The Church has been very supportive of national AIDS prevention efforts. The lack of sex education in schools is an obstacle, however, as is the low level of literacy in certain parts of the country.

A particular feature of the prevention strategy in Portugal is the emphasis on using the existing networks and infrastructure, such as government and nongovernmental organizations. Peer education (by, for example, injecting drug users) is being developed. The primary health care system is expected to take the lead in the further development of services.

Social and behavioural research

In plenary presentations and two working groups, the participants discussed the contribution of behavioural research to HIV and AIDS prevention and control programmes. The main focus was on the contribution that can be made by studies of knowledge, attitudes, behaviours and practices.

Experience with and Usefulness of Studies

A major characteristic of human society is diversity, expressed, for example, in terms of age, gender, sexual preference, and social or economic status. This heterogeneity within and between communities needs to be recognized and respected in the design and delivery of effective programmes. Surveys of people's knowledge, attitudes, behaviours and practices in relation to HIV and AIDS can help improve the understanding of the needs of certain groups. This can lead in turn to better aimed prevention efforts.

The necessity of studies of knowledge, attitudes, behaviours and practices (often called KABP studies) for the prevention and control of HIV and AIDS was readily accepted. As commonly understood, however, these studies were seen to be large, costly and time consuming, and thus difficult to interpret and rarely repeated. Nevertheless, AIDS will remain a pressing public health issue for the foreseeable future, and long-term changes in attitudes and behaviour are priorities. In this sense, there is time to initiate a series of continuing studies.

The information necessary for developing a profile of knowledge, attitudes, behaviours and practices can be collected through formal national or local KAPB studies and through informal sources. National surveys were seen to have long-term benefits, to be costly and general in orientation, and to present methodological problems. Local, more focused surveys were seen to be of value in the short term, better aimed, economical and likely to lead to action, but also to present methodological problems. Important information on knowledge, attitudes, behaviours and practices could also be obtained from informal sources and settings, including clinics for family planning, sexually transmitted diseases, and maternal and child health. The consensus was that approaches must vary according to the specified objectives of research, the target audience, and the social and cultural context.

In the European Region, KABP studies have been done in a number of countries. These investigations include representative surveys of the general population, as well as of specific groups such as homosexuals, injecting drug users and school-children. These studies have provided useful insights for programmes. For example, while high overall levels of knowledge about HIV and AIDS have been recorded in some countries, important differences indicate that older, less literate and rural populations are not so well informed. Such problems must be met in future work. Negative attitudes, such as favouring the isolation of seropositive people, are only too prevalent across the Region, indicating the extent of the educational task that still remains. This is paralleled by the common belief in members of the general population that AIDS is a problem for others and not likely to affect them as individuals.

As to behaviour, homosexual men have made substantial changes, and one or two countries show early indications of changes in needle-sharing. For the general population and young people in particular, studies in three or four countries have indicated a claimed reduction in casual sex and increased condom use. Whether these findings point to a genuine and sustained behaviour change, however, is not yet clear.

The data from KABP studies are mainly useful:

— in early situation assessment and policy formulation, particularly to identify subject areas and groups needing

special attention, and feasible and acceptable channels of communication;

— in monitoring changes in the AIDS-related perceptions of target populations, which helps to refine programme policies and activities; and

— in evaluating programme results, although it is often very difficult to be certain about linking particular results and interventions.

Considerable experience is now available on conducting and using these studies around the world, not only for the prevention and control of HIV and AIDS but also, for example, in programmes for family planning or the prevention of sexually transmitted diseases.

Obstacles and Ways to Overcome Them

This experience has highlighted a variety of obstacles to the proper use of these studies in the planning, implementation and evaluation of AIDS prevention and control programmes. These obstacles include the perception that many studies are too large, cumbersome and expensive, and hence unable to produce results that are sensitive to the demands of a rapidly changing field. There is also the concern that researchers do not communicate effectively with programme managers and decision-makers, failing to make clear the practical and policy implications of research work.

Cooperation

In practice, these difficulties can only be overcome through cooperation between researchers and programme staff. Approaches include:

(*a*) the giving of explicit recognition by national AIDS programmes to the importance of psychosocial factors and their use in the development and implementation of prevention and control initiatives;

(*b*) examining the arrangements made by national programmes for commissioning and managing research, so as to

overcome obstacles to the proper use of the results in guiding programme decisions;

(*c*) consulting researchers at the earliest stages of programme planning and involving them closely in implementation;

(*d*) ensuring that management structures (such as national AIDS committees) enable active participation by research specialists;

(*e*) defining clearly, at the outset, the contribution expected from research.

Two other approaches could be useful. The first entails clarifying the management of the research process. This would require closer collaboration between managers and researchers, but not at the expense of the objectivity and credibility of the research. This is an important requirement, if programmes are to avoid complacency and to benefit from properly conducted external critiques. The second approach involves ensuring that research results and analyses are relevant to AIDS policy and programmes, widely and quickly disseminated, and communicated in a format that is clear and convincing to makers of decisions and policy. Seminars or workshops for the key people and agencies in programme decisions can be a useful and convenient mechanism for ensuring the rapid dissemination of research findings.

The question of choosing the people or groups to conduct research on knowledge, attitudes, behaviours and practices raises a number of options and issues. The possible groups include researchers, field workers and members of target groups; each offers strengths and weaknesses. On the one hand researchers have appropriate academic training; field workers, a strong understanding of their clients; and target group members, a personal perspective on the issue. On the other hand, researchers may lack real interest in or sensitivity to the issue; field workers, appropriate training or time; and target group members, training, credibility and access to the research infrastructure. A mixture of people from each group, determined by the particular situation, would appear to have the best chance to obtain useful information.

Ensuring the use of the results of KABP studies and other types of social and behavioural research, whatever their source, is very difficult. The structures for liaison between researchers and the potential users of their results do not appear well developed. To help establish cooperation, it was suggested that workshops be developed to bring together these two groups. Such workshops would introduce researchers to national AIDS programme staff and their objectives, responsibilities, accountability and constraints. Programm managers and decision-makers could be made aware of t strengths and weaknesses of this and other types of research.

Other priorities

Research of adequate quality requires investment to develop an appropriate infrastructure, including trained personnel and facilities for the analysis of data. Much can be achieved, however, through learning from social research elsewhere, and through reviewing other sources, such as information systems and research in other areas (for example, population surveys), to determine how they may help to support work against HIV and AIDS.

Social scientists have described various theoretical models to explain health behaviour. These include:

— the individual adoption process model
— the social learning theory model
— the health belief model
— the behavioural causal model.

These models provide clues to understanding the way in which changes in behaviour may be encouraged and can be helpful in designing preventive strategies or directing research. Unfortunately, the extent to which any of these theoretical frameworks reflects the realities of behaviour in relation to AIDS is uncertain. The data from KABP studies and other social research should be used to construct a better understanding of the determinants of behaviour change and their link with shifts in knowledge, attitudes and practices. This will require such studies to look beyond knowledge-related questions to address more directly attitudinal and behaviour issues. The results could help develop more effective approaches.

There are four other priority tasks for social and behavioural research. First, specific studies in target populations or settings should be commissioned to provide more of the information needed to form the basis of health education and health promotion intervention. The second task is to examine the acceptability of AIDS prevention messages and the effectiveness of their integration into wider health education and health promotion work. This may help to determine the optimal approaches to the widening of the public health basis for AIDS prevention and control programmes. The work could start with the links between control programmes for AIDS and for sexually transmitted diseases. Third, strategies should be identified that promote shifts in group values or norms and result in the normalization and wider acceptance of safer sexual and drug use behaviour. Fourth is the examination of the processes involved in influencing policy-makers and involving other significant intermediaries such as community and religious leaders, other leaders of opinion, the mass media and professionals such as teachers and health workers.

The WHO Global Programme on AIDS has worked extensively to develop approaches and methods in health promotion, and social and behavioural research. This work could be made more widely known and the model protocols adapted for use in different countries. This would enable comparative analyses between countries to be conducted, while ensuring that countries' needs are met in accordance with their social and cultural contexts.

Monitoring and evaluation

In plenary presentations and two working groups, the participants discussed the practicalities of the monitoring and evaluation of AIDS programmes.

Many countries have carried out national-level education campaigns for the general public. Some of these have been evaluated using data from surveys of knowledge, attitudes, behaviours and practices, supported by information on media coverage, calls to telephone hotlines, the demand for testing for HIV antibody, condom sales and, to a lesser extent, trends in the incidence and prevalence of sexually transmitted diseases and HIV infection.

Data on the evaluation of specific interventions aimed at particular populations are patchy and difficult to assess. Even less is known about the evaluation of the control components of national programmes, such as the quality of the care given to people with HIV or AIDS, and measures to promote social tolerance and to counter discrimination. Further, the increasing recognition that appropriate monitoring and evaluation are integral parts of a national AIDS programme should be followed by an allocation of adequate funds as a protected component of programme budgets.

A distinction was made between monitoring and evaluation. Monitoring is the continuing process of tracking resources, activities and results to determine whether the programme is proceeding as planned. Evaluation is an assessment, often multifaceted, of whether a planned intervention or programme is achieving its objectives. Such an assessment may be made only once.

Evaluation Issues

Three types of evaluation may be distinguished. Formative evaluation is operational research that provides the information necessary to develop feasible interventions. Process evaluation assesses the activities necessary for implementing programme interventions, to determine whether they are occurring as scheduled. Outcome or effectiveness evaluation entails the systematic collection and use of information to determine whether each intervention in a programme is achieving its objectives.

Experience with designing, conducting and using evaluation studies suggests that common difficulties can be managed through attention to the following concerns:

— advance planning for and commitment to evaluation at the earliest stage of programme implementation;

— agreeing on the ownership and uses of the results;

— clarifying the management of the evaluation process;

— using evaluation methods that are relevant to the particular intervention or programme;

— involving the key parties; and

— sharing experience and learning from others.

Owing to limited resources, evaluation needs to be focused on important issues and problems, and innovative or novel approaches whose effectiveness has not been established. In addition, more can be done to apply more widely the conclusions drawn from specific, well conducted studies. The quality and comprehensiveness of evaluation often depend on the extent to which information systems are sufficiently developed to collect the necessary data. Nevertheless, much more can be done to make use of available data sources, such as the records of telephone hotlines, media reporting and, in some cases, anecdotal evidence.

A particular gap in evaluation work is the lack of studies concerned with the economic aspects of prevention and control interventions. The results of such studies would be particularly helpful in reformulating programmes.

Epidemiological surveillance systems are being gradually refined. While this is encouraging, more work needs to be done to make epidemiological data more useful for planning, monitoring and evaluation, and to establish better links between these data and those generated by social and behavioural research.

Quantitative indicator-based monitoring and evaluation data must often be supplemented by qualitative information. This can provide the insight necessary to understand the processes and mechanisms of the success or failure of various interventions.

Guidance on Monitoring and Evaluation

A WHO Expert Consultation held in May 1990 gave detailed scrutiny to issues in the monitoring and evaluation of AIDS education and health promotion programmes. The participants considered:

— the extent to which education initiatives for the general public have been monitored and evaluated;

— the main results of and lessons from these studies, and their influence on planning and programming decisions; and

— the measures necessary to overcome technical and organizational obstacles, so as to improve the validity, reliability, relevance and usefulness of monitoring and evaluation research.

The comprehensive report of the Consultation[a] is available from the Regional Office for Europe. The participants at the present Meeting agreed that it should be widely disseminated and carefully studied. The participants also endorsed the conclusions in the report and considered many of them to be of

[a] *Monitoring and evaluation AIDS education/health promotion programmes*. Copenhagen, WHO Regional Office for Europe, 1990 (unpublished document EUR/ICP/GPA 025).

wider relevance to HIV and AIDS prevention and control programmes. The recommended action includes:

— reviewing of monitoring and evaluation arrangements to examine their resources and links with planning and implementation;

— the making of formal statements by all national programmes of their policies, strategies and work plans, with clearly expressed objectives;

— the making of annual programme reviews and progress reports;

— the setting up of national focal points to set standards and systematically to collect, analyse and disseminate information;

— the strengthening, as far as possible, of existing information and surveillance systems to enable them to collect the necessary data; and

— the training of necessary staff.

The report of the Consultation also describes a detailed framework developed by the WHO Global Programme on AIDS for the monitoring and evaluation of prevention and control activities. It consists of: the selection of indicators, the setting of targets, the selection of methods for collecting necessary data, and the collection, analysis and use of information. This is a comprehensive but flexible system that could be adapted to suit the needs of an intervention or a whole programme in a variety of countries. In view of its importance and potential utility, this WHO initiative should be made more widely known, and its further development should be supported by implementation on a pilot basis in countries of the European Region.

Further, international cooperation to support national efforts could be encouraged, as recommended by the participants at the Consultation. European guidelines should be developed for monitoring and evaluation, including indicators and targets, methodology and protocols. This would also encourage more comparative international studies. In addition, European clearing-houses or reference centres should be set up to promote exchanges of skills and expertise.

Target audiences

In further plenary presentations and two working groups, the participants considered the processes used to select target populations for past and current HIV and AIDS prevention and control programmes in the Region, before going on to consider other groups and approaches.

There is now growing recognition that, while national-level programmes have an important role in providing an umbrella framework for all activities, the necessary changes in health behaviour are best encouraged through action based in the community. Selecting appropriate targets for prevention and control activities is thus critical.

Selection Criteria

In the past, the groups that were given priority either were defined from a simple epidemiological perspective (for example, the donors and recipients of blood and blood products) or emerged as a consequence of pressure from activists in the groups most affected (for example, homosexual men or people with haemophilia). To a large extent, this approach has been effective. Rapid progress has been made in the Region to eliminate HIV transmission through blood and blood products; and the members of organized homosexual communities have largely succeeded in containing the epidemic as it affects them.

Priority setting has also been influenced, however, by political needs, voluntary and nongovernmental organizations, and

other sectors with their own agendas, such as the armed forces. In addition, there is an increasing sophistication in identifying other groups with special needs (such as adolescents) and the impact of alcohol on behaviour related to HIV transmission.

The point is the expansion of the criteria for target definition to include more than epidemiology; this has directly affected resource allocation. Rather than waiting for new target groups and audiences to appear, national programmes should work to identify groups in need and support them as appropriate.

The focus on risk groups or target groups creates problems, however. Such classification can be perceived as discriminatory and stigmatizing and may alienate the people most in need of services and support. Further, inappropriate and inaccurate assessments of the risks to which members of crudely defined groups are exposed can destroy the effectiveness of information, education and counselling work. A better approach is to focus on risk behaviour rather than risk groups and on target audiences rather than self-identified target groups. This allows the segmentation of the population according to people's health promotion needs.

To reach target audiences effectively, a more sophisticated understanding is needed of the interaction of variables such as age, class, gender, sexual preference, ethnic background and culture. Further, the setting is important, because even when target audiences can be defined, identifying feasible and appropriate locations for reaching them may be difficult. For example, not all injecting drug users attend needle exchange centres.

Examples of the target audiences for HIV and AIDS prevention and control work in various parts of the Region include:

(*a*) men who have sex with men;

(*b*) drug users, including those who inject drugs;

(*c*) prostitutes and their clients;

(*d*) people with disabilities (including blindness, deafness and mental handicap) or problems such as illiteracy;

(*e*) people in prisons and other custodial institutions;

(*f*) young people;

(*g*) members of the armed forces;

(*h*) mobile groups such as tourists, business travellers, seafarers and lorry drivers;

(*i*) people with haemophilia;

(*j*) members of ethnic minorities;

(*k*) intermediaries such as political and religious leaders, journalists, community leaders, teachers and health care workers;

(*l*) women receiving antenatal care;

(*m*) people with occupational risk of exposure to infected blood, such as the police, tattooists, fire-fighters, hairdressers and acupuncturists, in addition to medical and health personnel; and

(*n*) people with HIV and AIDS.

While a few WHO meetings have been held to disseminate experience in working with some of these audiences, a systematic understanding is needed of their needs and the effectiveness of different approaches to them. Much can be learnt from the experience of successful work with homosexual men. To a lesser extent, information is also available on intervention with injecting drug users and prostitutes.

Newly Recognized Audiences and Needs

Previously neglected target audiences, in need of attention in the development of future programmes, include migrants and refugees. These and similar groups are less well integrated into their new societies and AIDS prevention and control programmes may be irrelevant to their cultural background. Owing to the isolation of these audiences from conventional social services, they are particularly vulnerable to HIV infection. The available experience suggests that community-based and other outreach approaches stand the best chance of meeting these people's needs. Nongovernmental organizations have demonstrated a particular ability to undertake such work, as they are able to be sensitive to and gain the confidence of these populations.

While a variety of educational initiatives for young people has been developed across the Region, certain needs are not being effectively met. AIDS education — as part of wider sex education and placed in the context of more comprehensive personal, social and health education — should be part of the curriculum of all schools. Such teaching should be culturally appropriate and take account of the emotional, biological and social aspects of the sexual attitudes and behaviour of young people in particular communities. At present, only a few countries give this need the necessary emphasis; in others, sex education in schools is still a matter of controversy. This undermines efforts to promote the health and wellbeing of an important segment of the population, which is particularly prone to risky behaviour.

Not all young people at risk can be reached in schools and colleges. Strategies using, for example, peer group approaches should be encouraged to reach the young in clubs and bars, on the street and in other informal settings, and in a style that is likely to be acceptable to them. A number of examples from around the world are now available to indicate how this can be done.

A further target audience, whose size increases as the epidemic spreads, comprises people with HIV or AIDS. They and their sexual partners, families and caregivers have particular needs for counselling and psychosocial support. In consequence, the implications for the mental health and social services must be addressed. People with HIV or AIDS should be enabled to lead as healthy and self-reliant lives as possible. They are also a valuable educational resource to reach others.

Appropriate and Effective Messages

In reaching target audiences, particular attention needs to be given to ensuring the appropriateness of messages. For example, young people who are not yet sexually active need a different approach than those who are more experienced. For the former, the message may be to delay sexual intercourse, while for the latter the use of condoms and a reduction in casual sex may need to be promoted.

Further, as public perceptions change, the context of messages may have to evolve. All AIDS education messages, however, should be truthful and clear, without provoking fear, blaming the victim or stereotyping or stigmatizing groups of people. Experience also suggests that health education and health promotion programmes are more successful when their messages and materials are tested — for relevance, realism, clarity and acceptability — on representatives of the intended audience. There should also be support in the form of adequate and accessible services offering, for example, counselling, condoms and HIV antibody testing.

Sustaining public interest and mobilizing society

In two working groups and plenary presentations, the participants discussed how all sections of society could be mobilized for and public interest sustained in HIV and AIDS prevention and control. The participants thought that this was an important issue to address, owing to the feeling that many people are weary of hearing so much about AIDS. Other people prefer to deny that it is a problem for them or their families and communities. Multifaceted and creative strategies have to be developed to challenge these complacent assumptions.

To start, the word complacency requires definition. Professionals tend to use it to censure members of the public who refuse to accept or follow the advice of experts. This may only create further denial. The real issue for both policy-makers and health educators is to define the level of concern and response that is appropriate for a particular community to express.

Further, the prevention and control of HIV and AIDS is clearly competing with other public health issues for resources, as well as for the public's attention. Other important issues are, for example, cardiovascular disease, accidents, smoking, drug abuse and immunization. Nevertheless, alliances can be made with people working on some issues, such as family planning, sexually transmitted diseases, policy development and life-skill education. While the interests of these and other areas may not always coincide at all levels or all times with those of work against AIDS, there are opportunities for mutually beneficial relationships.

Four Essential Allies

Mobilizing intermediaries is essential to sustaining public interest. In this context, four allies are essential: policy- and decision-makers, health, education and other professionals, the mass media, and nongovernmental and community organizations.

Well briefed makers of policy and decisions are critical; they can make things happen by allocating resources or sanctioning certain approaches. To help inform these potential allies, more creative communication approaches have to be developed, such as striking presentations of the social and economic effects of AIDS.

Professionals such as doctors, nurses, other health care workers and teachers have a special position in society and credibility with the public. As educators and trainers, they should be used more directly to reach out to their clients, who may be patients attending clinics or young people in schools and colleges. To do this, the needs of professionals for AIDS-related training should be addressed.

While AIDS is not primarily a health care issue, doctors, nurses and allied professionals, particularly those working in family planning and the control of sexually transmitted diseases, can be powerful allies. These groups, however, have their own biases, and training on the psychosocial aspects of HIV infection and AIDS is essential. It should be provided during both academic preparation and in-service training. These groups have a great potential for effective communication.

Teachers are other potential allies in sustaining public interest, particularly through sex and lifestyle education. It is a necessity to work not only with teachers but also with decision-makers in education, to secure their commitment to support teachers in providing appropriate information. Extending sex education to include its recreational, social and ethical aspects often requires a policy decision.

The powerful influence of the mass media is well recognized and most people's perceptions of the complex issues related to AIDS are shaped by television, radio and press coverage. (The media can also employ a number of other formats, including

theatrical and other cultural events.) While inaccurate or sensational coverage has done much harm, examples can be found from around the world showing how constructive partnerships with the media can be created. Much more of this needs to be done on a systematic basis.

To obtain media support in sustaining interest in AIDS, people working in AIDS prevention and control should become more familiar with the media and their needs. AIDS messages should be developed in consultation with journalists. The messages should be low key and cycled in order to avoid saturation. Both local and national media exposure should be encouraged, with the messages reflecting appropriate concerns. All messages should be realistic, to prevent having to retreat from a position at a later date, and linked when possible with other issues of public concern such as human rights.

The formulation of AIDS messages to meet specific needs can do much to generate and sustain public interest. Fear-arousing strategies stimulate short-term interest only. They are counter-productive in the long run, because frightened people tend to adopt denial as a mechanism for self-defence. Positive feedback, recognizing the changes in attitudes and behaviour that people (such as homosexual men) have made, can be useful to reinforce and sustain progress. Messages that promote solidarity by stressing benefit to the community can also generate momentum.

Methods

The methods for sustaining public interest in AIDS were discussed. The positive approaches included working with target audiences, decentralizing strategies to meet local needs and providing positive information. The key point is to present information in ways and venues that make it more acceptable and appealing.

Programme structures and processes need to be sufficiently sensitive and flexible to respond to a rapidly changing social environment. This includes leading public opinion and, when necessary and feasible, challenging public prejudices so as to modify the attitudes and norms that hinder people from making effective changes.

Conclusions

Social and Behavioural Research

1. Useful social and behavioural research would have designs and methods specific to the planned interventions and affordable within the programme budget. Studies of knowledge, attitudes, behaviours and practices need not be large-scale, population-based surveys, but syntheses of known information on selected target audiences.

2. Policy-makers and programme managers would profit from information on the value of such research, and a realistic appreciation of what it can and cannot show, given the relative uncertainty of attributing particular results to particular interventions.

3. A priority for social research is clarifying the determinants of behavioural change and their links with shifts in knowledge, attitudes and beliefs.

Monitoring and Evaluation

4. It would be useful to make clear the distinction between and the scope of monitoring and evaluation, and, before any review, to reach agreement on the use and dissemination of the resulting information.

5. The review of current systems of data collection, analysis and reporting for epidemiological surveillance would provide better linkage with data from social and behavioural research, and improve the usefulness of epidemiological data in planning, monitoring and evaluation.

6. Deficiencies in quantitative data should not prevent action. Qualitative and anecdotal information and media reporting, for example, are all important barometers of the effectiveness of AIDS prevention and control programmes.

Target Audiences

7. The targeting by AIDS policies and programmes of risk behaviour and target audiences, as opposed to risk groups and target groups, would allow better segmentation of the population, according to health promotion needs instead of self-identified group membership.

8. The consideration of setting is important in the definition of target audiences, to identify all feasible and appropriate locations for access to these audiences.

9. Priority target audiences include migrants, refugees and others who are not well integrated into the surrounding society and culture. In their new environment, these groups are particularly vulnerable to HIV infection and less affected by AIDS prevention and control programmes.

10. Community-based and outreach programmes, particularly those delivered through organizations and groups that are socially and culturally relevant to target audiences, are likely to achieve the best results.

11. Because the membership of target audiences and self-identified target groups is fluid, the repetition of AIDS prevention and control programmes is necessary to reach new members.

Sustaining Public Interest

12. The four essential allies in sustaining public interest in and concern about AIDS are decision-makers, health and education professionals, the mass media, and nongovernmental and community organizations. Sustaining their interest and concern is important.

13. Creating alliances is important for reaching the widest possible range of people. Doctors and nurses, for example, particularly those working in family planning and the control of sexually transmitted diseases, have a great potential for increasing awareness through communication with their clients.

14. Continuing dialogue with target audiences is a requisite for maintaining the credibility and acceptability of AIDS prevention and control programmes. Public interest is more likely to be sustained when programme messages reflect and address the concerns of groups in the population.

AIDS Policies and Programmes

15. AIDS prevention and control efforts benefit from being linked to, but not submerged in, the mainstream of public health development. Such links support mutual learning and strengthen the programmes involved. Further, they are a constructive movement towards more comprehensive health promotion strategies as part of progress towards health for all.

Support for National Programmes

16. The implications of HIV infection and AIDS concern all Member States of the European Region, but differ between areas in and groups of countries. Working through the Regional Office for Europe, the WHO Global Programme on AIDS has a crucial role in supporting national AIDS programmes to help sustain their commitment to prevention and control work. Specifically, WHO is best placed to undertake the following activities:

(*a*) developing guidelines on and common protocols for social and behavioural research, indicators for monitoring and evaluation, epidemiological surveillance, and the care of people with HIV or AIDS;

(*b*) developing policies that could serve as models to Member States on such issues as protecting human rights and countering discrimination;

(*c*) promoting international action on, for example, educational programmes for migrants, refugees and travellers;

(*d*) liaising with the activities of other international bodies such as those of the United Nations system, the Commission of the European Communities, the Council of Europe, and international nongovernmental organizations; and

(*e*) promoting the exchange of information and experience.

In carrying out the last of these activities, the Programme could provide critical comparative reviews of interventions in different parts of the Region. The work of WHO collaborating centres (or other clearing-houses or reference centres) on specific topics or issues could also be useful. Such work, however, must be relevant to the assessed needs of the national programmes of the Region. A further useful medium for the exchange of information and experience is WHO meetings. These could be made more relevant by focusing on common problems or on countries with similar needs or at similar stages of response to the epidemic. Such meetings should involve senior decision- and policy-makers, as well as researchers and field workers. Finally, technical cooperation, including exchanges of experienced personnel between countries, would be a valuable resource.

Recommendations

Social and Behavioural Research

1. Each Member State should use existing information to assemble a national epidemiological and risk profile for AIDS, in order accurately to determine the priority areas and need for research on knowledge, attitudes, behaviours and practices.

2. The work of the WHO Global Programme on AIDS in social and behavioural research is commended, should be made more widely known, and should be adapted for use in countries as necessary and feasible. Further work should be done after assessing, through expert consultations, the priority needs of national AIDS programmes.

Monitoring and Evaluation

3. Monitoring and evaluation should be given greater recognition as integral components of national AIDS programmes. This recognition should include the explicit allocation of resources for this purpose.

4. The work of the Global Programme on AIDS in developing a detailed framework for the monitoring and evaluation of prevention and control programmes is commended and should be made available for implementation in the European Region.

Target Audiences

5. The role of intermediaries such as providers of health, education and social services (both paid staff and volunteers) is central to the success of work to prevent and control AIDS. This role should be strengthened by immediate AIDS training for these people and the incorporation of AIDS issues into future routine training.

6. The curricula in all schools and colleges should provide for AIDS education in the context of a coordinated programme of personal, social and health education, which should include culture-relevant approaches to sex education.

7. WHO should compile a regional directory of programmes and interventions for various target audiences. This would be a useful resource to foster the exchange of experience and to encourage collaboration between countries.

Sustaining Public Interest

8. The mass media remain the most efficient means of reaching the largest number of people. AIDS policy-makers and programme managers need to establish partnerships with journalists to encourage innovative, continuous and cost-effective information campaigns that inform and educate the public.

AIDS Policies and Programmes

9. The creativity, vigour and momentum of current AIDS-related programmes should not be undermined. The practical considerations of cooperation between programmes should be addressed at a special regional meeting.

Support for National Programmes

10. Some countries in the Region have limited resources and now report a low prevalence of HIV infection. Preventing the

growth of the problem requires priority consideration. Timely action now can have great future benefit.

11. The work of the Global Programme on AIDS in Europe should be constantly reviewed to ensure its relevance and effectiveness. Such a review should include periodic scrutiny of the progress made in implementing the recommendations of previous WHO meetings.

12. The role and functioning of WHO collaborating centres should be reviewed to ensure that their work plans are relevant to regional needs, and that communication with other relevant centres is adequate and efficient.

Annex 1

Working papers[a]

ICP/GPA 058/6	"Think globally — act locally" — practical issues in the evaluation of local AIDS programmes, by *M. Kapila*
ICP/GPA 058/7	Assessment of HIV prevention programmes — experience gained in Switzerland, by *B. Somaini*
ICP/GPA 058/8	HIV/AIDS health promotion and "the groups in need of further attention", by *P. Aggleton*
ICP/GPA 058/9	HIV/AIDS trends in Europe, by *R. Ancelle*
ICP/GPA 058/10	HIV/AIDS prevention strategies in Portugal, by *L. Ayres*
ICP/GPA 058/11	Effectiveness of different models for changing health behaviour, by *J. Santos Lucas*
ICP/GPA 058/12	The health promotion rationale in the prevention of HIV transmission, by *J. Branckaerts*
ICP/GPA 058/13	European responses to HIV/AIDS-related discrimination, by *S.-E. Ekeid*

[a] Copies are available from the Global Programme on AIDS, WHO Regional Office for Europe, 8 Scherfigsvej, DK-2100 Copenhagen Ø.

ICP/GPA 058/14	Highlights from previous European regional meetings on HIV/AIDS, by *A. Gromyko*
ICP/GPA 058/15	Ensuring coordination between national AIDS programmes and other sectors of society, by *H. Mikkelsen*
ICP/GPA 058/16	HIV/AIDS-related mental health problems and interventions, by *J. Sampaio Faria*
ICP/GPA 058/17	Current status and future direction of HIV/AIDS prevention and control policies in the European Region, by *S. Wayling*

Annex 2

Participants

Albania

Dr Silva Bino, Infectious Disease Hospital, c/o Ministry of Public Health of the Socialist People's Republic of Albania, Tirana

Dr Besim Nuri, Research Institute of Hygiene and Epidemiology, c/o Ministry of Public Health of the Socialist People's Republic of Albania, Tirana

Austria

Dr Helga Halbich-Zankl, Volksgesundheit, Bundeskanzleramt, Vienna

Dr Jean Paul Klein, Abteilung für Allgemeine Hygiene und Epidemiologie, Bundeskanzleramt, Sektion VI, Vienna

Belgium

Dr Francis Dondeyne, Directeur à l'Inspection de la santé, Ministère de la communauté flamande, Brussels

Mr Vincent Magos, Attaché au Cabinet du ministre de la santé de la communauté française, Brussels

Bulgaria

Dr David Jeroham, Psychiatrist, Sofia

Czech and Slovak Federal Republic

Dr Antonin Brzek, Chief, AIDS Counselling Centre, Institute of Sexology, Prague

Dr Viktor Prikazsky, Chief Medical Officer of Health, Department of Epidemiology, Poprad

Denmark

Professor Jørn Olsen, Institute for Social Medicine, University of Aarhus

Dr Niels Peter Rothgardt, Head, AIDS Secretariat, National Board of Health, Copenhagen

Finland

Dr Olli Haikala, Senior Medical Officer, National Board of Health, Helsinki

Ms Tarja Tamminen, Information Officer, National Board of Health, Helsinki

France

Mrs Anne Bunde-Birouste, Coordonnateur de projets, Division des projets dans la collectivité, Agence pour la prévention du SIDA, Vanves

Dr Annie Serfaty, Médecin de santé publique, Division du SIDA, Direction générale de la santé, Ministère de la solidarité, de la santé et de la protection sociale, Paris

German Democratic Republic

Professor Erwin Günther, Direktor, Universitäts-Hautklinik, Jena

Dr Jürgen Kölsch, Humboldt-Universität, Charité, Klinik und Poliklinik für Hautkrankheiten, Berlin

Germany, Federal Republic of

Professor Michael Ermann, Abteilungsvorstand, Psychotherapie und Psychosomatik, Munich

Mr Frank Niggemeier, Koordinierungsstabes AIDS, Bundesministerium für Jugend, Familien, Frauen und Gesundheit, Bonn

Greece

Dr Anna Kokkevi, Department of Psychiatry, Athens University Medical School

Professor Kostas Stefanis, Department of Psychiatry, Athens University Medical School

Hungary

Mrs Agnes Lukats, Deputy Director, Health Promotion Centre of Budapest

Dr Peter Makara, Scientific Director, National Institute for Health Promotion, Budapest

Iceland

Dr Kristjan Erlendsson, University Hospital, Reykjavik

Ms Sigridur Jakobinudottir, Secretary, National Committee on AIDS, Ministry for Health and Social Security, Reykjavik

Ireland

Dr James Kiely, Medical Officer, Department of Health, Dublin

Israel

Professor Abraham Morag, Chairman, Advisory Board for AIDS Education and Information, Ministry of Health, Jerusalem

Italy

Dr Chiara Monzali, Ministry of Health, Rome

Luxembourg

Dr Danielle Hansen-Koenig, Directeur général adjoint de la santé, Luxembourg

Dr Robert Hemmer, Président du Comité de surveillance du SIDA, Service des maladies infectueuses, Centre hospitalier de Luxembourg

Malta

Dr Gauden Galea, Director, Health Education Unit, Department of Health, Valletta

Monaco

Mr Maurice Gaziello, Directeur de l'action sanitaire et sociale, Département de l'intérieur

Netherlands

Ms Marga Beckers, Secretary, Care Section, National Committee on AIDS Control, Amsterdam

Mr Hans Moerkerk, Secretary, National Commission on AIDS Control, Ministry of Welfare, Health and Cultural Affairs, Rijswijk

Norway

Ms Jo Kittelsen, National AIDS Coordinator, Directorate of Health, Oslo (*Vice-Chairperson*)

Ms Anne-Lise Middelthon, Senior Executive Officer, National AIDS Unit, Directorate of Health, Oslo

Poland

Dr Zygmunt Dajek, Institute of Venereology, Medical Academy, Warsaw

Dr Wieslaw Jaszczynski, Under-secretary of State, Chief Sanitary Inspector, Ministry of Health and Social Welfare, Warsaw

Portugal

Dr Maria Manuela Santos Pardal, Director, Health Education Service, General Directorate for Primary Health Care, Lisbon (*Chairperson*)

Dr Teresa Nunes Vicente, Director, Centre for the Study and Prevention of Drug Abuse, Coimbra

Spain

Dr Rafael de Andrés Medina, General Secretary, National Plan on AIDS, Ministry of Health and Consumer Affairs, Madrid

Dr Carmen Sanchis Pinol, Deputy Director for Research, Institute of Health "Carlos III", Madrid

Sweden

Ms Anita Karamustafa, Senior Administrative Officer, Division for AIDS Prevention, National Board of Health and Welfare, Stockholm

Ms Ulla-Karin Wahlgren, Senior Administrative Officer, Division for AIDS Prevention, National Board of Health and Welfare, Stockholm

Switzerland

Dr Thérèse Stutz, Leiterin der Gruppe AIDS-Prävention der Zentralstelle für AIDS-Fragen, Bundesamt für Gesundheitswesen, Abteilung Medizin, Liebefeld

Mr E. Zimmermann, Institut de médecine sociale et préventive, Lausanne

Turkey

Dr Tolunay Ozcam, Directorate-General of Primary Health Care, Ministry of Health, Ankara

Dr Yasemin Yahnici, Laboratory Chief, Refik Saydam Hygiene Institute, Ankara

USSR

Dr Oleg F. Bogatyrev, Chief, AIDS Unit, Epidemiological Department, Ministry of Health of the USSR, Moscow

Dr Irina J. Eramova, Scientist, AIDS Laboratory, Central Research Institute of Epidemiology, Ministry of Health of the USSR, Moscow

United Kingdom

Dr Eileen Doris Rubery, Senior Principal Medical Officer, Head of Division, Communicable Disease Including AIDS, Department of Health, London

Mr Roger Tyrrell, AIDS Unit, Department of Health, London

Yugoslavia

Dr Dunja Piskur Kosmac, Director, University Institute of Public Health and Social Welfare, Ljubljana

Dr Vlasta Hrabak-Zerjavic, Epidemiological Medical Expert, Department of Epidemiology, Institute of Public Health of Croatia, Zagreb

Commission of the European Communities

Dr Hubert Petit, Administrator, Directorate-General of Employment, Industrial Relations and Social Affairs, Luxembourg

Observer

Dr André Stroobant, Chef de la Section épidémiologie, Institut d'hygiène et d'épidémiologie, Brussels, Belgium

Temporary advisers

Dr Peter Aggleton, Head of HIV/AIDS Research, Bristol Polytechnic, United Kingdom

Dr Rosemarie Ancelle, WHO Collaborating Centre for AIDS, Institut de médecine et d'épidémiologie africaines et tropicales, Hôpital Claude Bernard, Paris, France

Professor Laura Ayres, Deputy Director, National Institute of Health, Lisbon, Portugal

Dr Mukesh Kapila, Deputy Director, AIDS Programme, Health Education Authority, London, United Kingdom (*Rapporteur*)

Dr Joao Santos Lucas, National Institute of Health, Lisbon, Portugal

Dr Bertino Somaini, Federal Office of Public Health, Liebefeld, Switzerland

World Health Organization

Regional Office for Europe

Dr Rafael Bengoa, Medical Officer for Health Policies and Planning

Dr Jan Branckaerts, Acting Health Education Specialist, Global Programme on AIDS

Dr Svein-Erik Ekeid, Short-Term Professional, Global Programme on AIDS

Dr José G. Sampaio Faria, Regional Officer for Mental Health

Dr Alexandre Gromyko, Medical Officer, Global Programme on AIDS (*Secretary*)

Dr Ilona Kickbusch, Director, Lifestyles and Health

Mr Henning Mikkelsen, Short-Term Professional, Global Programme on AIDS

Mr Steven Wayling, Short-Term Professional, Global Programme on AIDS

Headquarters

Mr Tony Burton, Surveillance, Forecasting and Impact Assessment, Global Programme on AIDS

Dr Manuel Carballo, Chief, Social and Behavioural Research, Global Programme on AIDS

Dr Rosemarie Erben, Chief, Health Promotion, Global Programme on AIDS

Dr Nina Ferencic, Health Promotion, Global Programme on AIDS

Dr David Heymann, Chief, Epidemiological Support and Research, Global Programme on AIDS

Dr Michael H. Merson, Director, Global Programme on AIDS

The spread of HIV infection and AIDS depends very much on the way people behave. Individuals from some groups have been successfully persuaded to modify behaviours that put them at increased risk of HIV infection. The salient questions for future AIDS prevention and control programmes are how did this modification actually come about and how can the progress achieved be consolidated?

Psychosocial factors have a vital role in influencing the behaviour of both individuals and groups. At the fourth in a series of WHO meetings on AIDS issues, 76 participants met to discuss the psychosocial aspects of HIV infection and AIDS, and to look at the importance of behavioural factors in planning and evaluating strategies for prevention and control.

They felt that studies of knowledge, attitudes, behaviours and practices can be a valuable tool for national AIDS programmes if carried out and used appropriately. They emphasized the importance of maintaining the quality of programme monitoring and evaluation. They identified school and college students as vital target audiences for AIDS education, and providers of health, education and social services for training in AIDS issues. Finally, they encouraged policy-makers and programme managers to establish partnerships with journalists, as the most efficient means of reaching the largest number of people.

This report will be a useful and encouraging review for decision-makers, managers of national AIDS programmes, professionals in the health, educational and related sectors, and the public.

ISBN 92 890 1127 0

Price: Sw.fr. 10.-